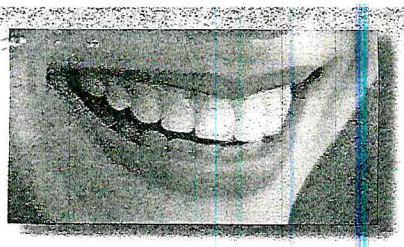


Welcome

Thank you for selecting our dental healthcare team!
We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Patient # _____
SS#/SIN _____
Date _____

Patient Information (CONFIDENTIAL)

Patient's Sex ☐ F ☐ M

Name _____ Birthdate _____ Home Phone _____
Address _____ City _____ State/Prov. _____ Zip/P.C. _____
Email _____ Cell Phone _____
Do you prefer to receive calls at your: ☐ Home ☐ Work ☐ Cell Phone
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
If Student, Name of School/College _____ City _____ State/Prov. _____ ☐ Full Time ☐ Part Time
Patient or Parent/Guardian's Employer _____ Work Phone _____
Business Address _____ City _____ State/Prov. _____ Zip/P.C. _____
Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____
Whom may we thank for referring you? _____
Person to contact in case of emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____
Address _____ Home Phone _____
Email _____ Cell Phone _____
Driver's License# _____ Birthdate _____ Financial Institution _____
Employer _____ Work Phone _____ SS#/SIN _____
Is this person currently a patient in our office? ☐ Yes ☐ No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

☐ Cash ☐ Personal Check Credit Card ☐ VISA ☐ MasterCard ☐ I wish to discuss the office's payment policy.

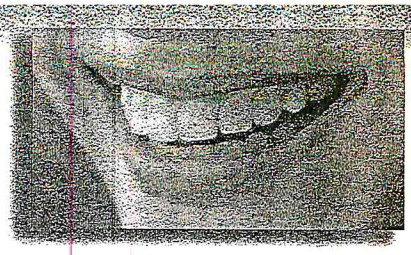
Insurance Information

Name of Insured _____ Relationship to Patient _____
Birthdate _____ SS#/SIN _____ Date Employed _____
Name of Employer _____ Union or Local # _____ Work Phone _____
Address of Employer _____ City _____ State/Prov. _____ Zip/P.C. _____
Insurance Company _____ Group # _____ Policy/ID # _____
Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____
How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____
Birthdate _____ SS#/SIN _____ Date Employed _____
Name of Employer _____ Union or Local # _____ Work Phone _____
Address of Employer _____ City _____ State/Prov. _____ Zip/P.C. _____
Insurance Company _____ Group # _____ Policy/ID # _____
Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____
How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

Over Please



Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain _____	☐	☐
3. Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking? _____	☐	☐
4. Have you ever taken Fen-Phen/Redux?	☐	☐
5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?	☐	☐
6. Have you taken Viagra, Revati, Cialis or Levitra in the last 24 hours?	☐	☐
7. Do you use tobacco?	☐	☐
8. Do you use controlled substances?	☐	☐

	Yes	No
10. Are you wearing contact lenses?	☐	☐
11. Are you allergic to or have you had any reactions to the following?		
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other _____		
12. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	☐	☐
13. Women Only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

9. Do you have or have you had any of the following?

	Yes	No
High Blood Pressure	☐	☐
Heart Attack	☐	☐
Rheumatic Fever	☐	☐
Swollen Ankles	☐	☐
Fainting / Seizures	☐	☐
Asthma	☐	☐
Low Blood Pressure	☐	☐
Epilepsy / Convulsions	☐	☐
Leukemia	☐	☐
Diabetes	☐	☐
Kidney Diseases	☐	☐
AIDS or HIV Infection	☐	☐
Thyroid Problem	☐	☐
Heart Disease	☐	☐
Cardiac Pacemaker	☐	☐
Heart Murmur	☐	☐
Angina	☐	☐
Frequently Tired	☐	☐
Anemia	☐	☐
Emphysema	☐	☐
Cancer	☐	☐
Arthritis	☐	☐
Joint Replacement or Implant	☐	☐
Hepatitis / Jaundice	☐	☐
Sexually Transmitted Disease	☐	☐
Stomach Troubles / Ulcers	☐	☐
Chest Pains	☐	☐
Easily Winded	☐	☐
Stroke	☐	☐
Hay Fever / Allergies	☐	☐
Tuberculosis	☐	☐
Radiation Therapy	☐	☐
Glaucoma	☐	☐
Recent Weight Loss	☐	☐
Liver Disease	☐	☐
Heart Trouble	☐	☐
Respiratory Problems	☐	☐
Mitral Valve Prolapse	☐	☐
Other _____	☐	☐

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐

	Yes	No
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials? If yes, date of placement _____	☐	☐
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐

Authorization and Release

Payment is due in full at the time of treatment unless prior arrangements have been approved.
This office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered to my insurance company.
I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

X _____ _____

Signature of patient (or parent/guardian if minor) Date

FAMILY DENTISTRY
HOOPER

YOUR DENTAL INSURANCE IS YOUR RESPONSIBILITY…BUT WE CAN HELP…Regardless of what we might calculate as your dental benefit in dollars, we must stress the fact that you the patient are responsible for the TOTAL TREATMENT FEE. As a courtesy to you, we do accept assignment of benefit payments from most insurance companies. This will reduce your immediate, out-of-pocket expenditures. Any estimate our office gives is based on limited information obtained from your insurance company.

We allow 60 days for your insurance company to make payment. AFTER THIS TIME, ALL INQUIRIES (FOLLOW-UPS) ON PAYMENTS DUE BECOME YOUR RESPONSIBILITY.

Please sign below to confirm acceptance of your financial responsibilities.

_____ _____

Patient's/Guarantee's Signature Date

Hooper Family Dentistry, Inc
5148 Airline Drive
Bossier City, LA 71111

Hooperfamilydentistry.com

(318)742-2272

hooperfamilydentistry@gmail.com

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly

- Obtain payment from third-party payers

- Conduct Normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices, containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Private Practices.

Hooper Family Dentistry
5148 Airline Drive
Bossier City, LA 71111

Alternative Contact/Preferred method of Communication Form

We at Hooper Family Dentistry take your dental confidentiality very seriously. We will not and cannot release information without your written authorization.

This authorization allows our staff to speak only with an individiual(s) you designate in the event you are not available to receive phone calls or you have an adult member that helps coordinate your dental care. You should not designate your doctor.

As part of our Patient Privacy Policy, we will no leave any dental information with any other person unless you specifically authorize below:

Hooper Family Dentistry, Inc
5148 Airline Drive
Bossier City, LA 71111

Hooperfamilydentistry.com

(318)742-2272

hooperfamilydentistry@gmail.com

☐ I do NOT authorize to receive information regarding my dental care

☐ I authorize my physician and the employee of this office to speak with:

Person:

Relationship:

Phone Number(s):

Check all that apply:

☐ Appointments ☐ Account/Bill ☐ Lab Results ☐ Test Results ☐ Dental Care

☐ Treatment

Please check your preferred methods of communication:

☐ Home Phone (Answering Machine) ☐ Cell phone (voice mail)

☐ Mail ☐ Work Phone

☐ Text Message ☐ Email

Electronic Communication is my preferred method:

◯ Yes ◯ No

(In order to electronically communicate to you or anyone you designate, we are required to have your written permission)

This authorization will remain in effect unless changed by me while I am a patient at this office. It is my responsibility to notify this office of changes and to complete a new form.

Any problems and/or questions concerning this form are to be referred to the Hooper Family Dentistry staff.

I agree that should I desire to revoke this authorization, I will give written notice.

Signature: _____ Date:

Response Date: